The Changing Role of County Hospitals in California

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WE ARE CELEBRATING TODAY a compact between the County of San Diego and the University of California, San Diego—a compact designed to promote better health care and to enhance medical education. The goals of the County and of the University in this endeavor represent important interests of the people both in the County and in the State. For undertaking it, therefore, you are to be congratulated by all of us.

On the part of the University, the assumption of responsibility for direction of services in the County Hospital is another step toward assuring adequate resources for education of physicians and other health personnel needed in the State. Perhaps even more important, it signifies once again the intent of the University to link itself with the community, to carry out its responsibility for education and research through helping to meet community needs for service. This commitment to public service will improve the quality as well as add to the quantity of physicians and others who will gain their education here.

The compact we are celebrating today will enhance the quality of medical education because teachers and students will be participating in the transformation of a major county hospital into an institution for a new and higher type of health service. San Diego has reason to be proud of the facility it has developed here and the history of its service to people in this County.

But a new day has come to the county hospital in California. This State has again taken the lead in providing for the conversion of county hospitals into community hospitals. About a century ago, the State placed upon the counties in California the responsibility for care of the indigent sick. This responsibility the counties met by building separate hospitals for the poor. Over the years, many of these public hospitals, as in San Diego, have developed a high technical level of health care and have maintained an important resource for graduate medical education. However, it was still segregated care. It carried an element of compulsion because persons who sought care there could not obtain it elsewhere.

Our national policy now calls for desegregation, in health as well as in educational and other endeavors. California is the first major state to extend this policy to include breaking down the segregation of health care based on economic as well as on racial and other grounds. The California Medical Assistance Program, initiated 1 March 1966, provides a new opportunity for most of the poor in this State, although not all of them, who were formerly obliged to seek health care at county hospitals. This is the opportunity to obtain their care from physicians and in hospitals of their own choosing, with the bills to be paid by the State. In this way, the counties are relieved of a big share of the obligation to provide care of the indigent sick. Poor patients who historically filled the county hospitals may henceforth enter any hospital in the community.

The desegregation of health care provided in the California Medical Assistance Program goes both ways: The new law specifically encourages counties, at the option of the Board of Supervisors, to open county hospitals to all patients in the community. These hospitals need no longer restrict their care to the indigent. This has been spoken of as the conversion of county hospitals into community hospitals.

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In the future, then, county hospitals will begin to serve the entire community and admit patients of all social and economic strata. Many indigent patients are already entering other hospitals in the community; the county hospital will cease being "the hospital for the poor"; patients who pay their own way or whose care is charged to labor-management health and welfare funds, or to the Social Security Fund or other sources for payment will enter the county hospital. Segregated health care for the poor will be a matter of history and any social stigma attaching to the county hospital will vanish.

For the immediate future, the county hospital will still carry responsibility for the care of those who are both poor and doubly unfortunate in not falling into one of the categorical aid groups. For example, adult persons who are poor, but who have no children and are not over 65 years of age or blind or otherwise disabled, are not eligible for the California Medical Assistance Program benefits. If in need of health care, they must continue to obtain it at the county hospital. This limited group will require only a relatively small share of the county hospital services, and it is to be hoped that further social advances will soon enable even these persons to secure health care of their own choice.

In their new role of serving the entire community, the county hospitals in California will continue to offer opportunities for graduate medical education, that is, the training of medical specialists. Several will maintain or will newly establish links with medical schools, as in San Diego, and thus be a resource for undergraduate medical education as well. This will tend to improve even further the quality of care. Every physician knows that one of the most noteworthy signs of excellence in medicine is participation in medical education. County hospitals generally in this State have achieved eminence in this regard and they will surely cling to the superior status and many advantages which affiliation with medical education affords.

However, one major change will occur in the relationship of county hospitals to medical education, and this will be a change for the better. Patients will no longer be known as or treated as "clinical material." Probably nothing in the training of physicians in this country so typifies its greatest defect as the term "clinical material." As used by medical educators it has often implied that patients, and especially patients whose care served as a basis for physician training, were mere biological specimens available for teaching. It is not remarkable that many young physicians who spent years in such an atmosphere acquired attitudes of disrespect which were later resented by patients.

Henceforth patients in California, even those who are poor, will not have to present themselves as "clinical material." Medical educators and graduate and undergraduate medical students, who have not already done so, will rapidly learn that the patient is first of all a human being to be treated with dignity. And people will learn that one reliable sign of good health care is its connection with medical education. Just as physicians know this truth, people generally will learn it. This learning will necessarily be gradual because long-established ideas connecting medical teaching with care of the poor must be overcome. But such prejudices do melt with change in circumstances.

Thus one element in the future of the county hospital will be maintenance of excellence through a relationship to medical education, with patients freely choosing to obtain their care in such a situation.

In addition, county hospitals as centers of high-quality care will serve as the foci for new advances in medical science. Take just one example: Medicine appears to be on the verge of tremendous developments in the transplantation of human tissues and organs, and artificial substitutes for them. Success has already been achieved with blood, arteries, cornea and kidney. How can such achievements be made more generally available to people, and what will be next? County hospitals will be in the midst of the advances involved in answering these questions.

In addition to being involved in these exciting technological developments, county hospitals affiliated with medical schools will have an even more challenging opportunity. That is the opportunity to serve as the base for truly comprehensive care. One of the strongest and among the most justifiable complaints against modern medical care is the complaint against fragmentation. Nowadays, care tends to be episodic rather than continuous. The individual with pain or some other symptom may obtain first-rate diagnostic and therapeutic care for the particular episode of illness. But that is not enough. What is needed, and increasingly expected, is a sense of responsibility by the physician and the rest of the health care team for continuing health care of the individual.

The training of physicians in the recent past has emphasized accurate diagnosis and treatment, but without much regard for continuity of care. Pediatrics has been somewhat of an exception. The future of medicine, with acute illness being relatively well controlled, lies more in the direction of personal health care with the aim of assuring health rather than merely treating disease. To accomplish such a change of direction will require substantial innovation in medical education.

One approach is to have the medical faculty (the staff of a county hospital) and its students, assume total responsibility for health care of a specified population group—perhaps 20,000 to 30,000 persons. Every element of health care for all persons in this population would be provided—at home, in office or clinic, in hospital or other facility. A county hospital serving as the teaching facility for a medical school could offer the entire gamut of services that modern medical science has made available, from minor, routine care to the most complex and difficult. But the important factor is that a new commitment would be established, a commitment to preserve and extend health, not merely to treat disease. For the population being served, the occurrence of a case of measles, now that an effective vaccine is available, or a death from cancer of the cervix, now that means are at hand to avoid such death, or indeed the occurrence of any other disease event that can be prevented, would be regarded properly as a shame. This sense of responsibility for health of an entire population would tend to stimulate in young physicians an attitude of health maintenance going beyond readiness to undertake diagnosis and treatment. Experience in such a situation would yield vastly different physicians from those of the last generation trained in crowded clinics and at the bedside of acutely ill patients only.

Still another implication of the conversion of county hospitals into community hospitals is that the county hospitals may join on an equal footing other hospitals planning for and establishing a national community-wide hospital service system.

Thus county hospitals in California are entering upon the new day in medical care with greater opportunities than ever before. I believe that they will continue to maintain a position of leadership in quality of care and in the training of physicians. Further, they can help to reintroduce both a humanistic attitude and a health orientation which medical education has been lacking during the past few decades.

The San Diego County Hospital by virtue of its history, its first-rate staff, its physical facilities and now its affiliation with the University of California, San Diego Medical School may be a leader in this development.